Questions for Q and A on Title II (Medicare Advantage) Regulation

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A. General Regulation

Q1: What is contained in the proposed regulations implementing the Medicare Modernization Act?

A1: For the new Medicare Advantage (MA) program and the new drug benefit, CMS is publishing two separate, but related, proposed rules in order to implement various provisions of the Medicare Modernization Act (MMA). We believe publishing these regulations simultaneously is the most efficient and simple way to solicit meaningful public comment. The first proposed rule (CMS-4069-P) is on the new MA program as established in Title II of the MMA. The MA program retains most of the existing provisions of the former Medicare+Choice (M+C) program. The second proposed rule (CMS-4068-P) provides implementation information on the new Part D Medicare drug benefit as established in Title I of the MMA. This regulation proposes rules for prescription drug plans and Medicare Advantage plans offering drug benefits. It also addresses how the retiree drug subsidy will operate for employers agreeing to continue to provide drug benefits to their retirees. Each proposed rule invites comment on a variety of issues on which CMS would like to have input from interested and affected parties.

Q2: How do I submit comments on these proposed rules?

A2: CMS will accept comments on both proposed rules for 60 days following their publication. Comments may be submitted either in writing or electronically. Specific details about where and how to comment are included in each Federal Register document. Comments will be accepted through Monday, October 4, 2004.

Q3: Many viewed the BBA regulation as burdensome. How have you reduced the burden in this regulation?

A3: Even before passage of the MMA, we have taken significant steps to reduce administrative burden. These measures include:

- Automating the ACR submission process.
- Expanding "file and use" which expedites review of marketing materials.
- Reducing reporting requirements related to physician incentive plans.
- Eliminating all new, mid-year plan requirements that are not legislatively mandated.
- Hiring an outside contractor to process retroactive payment adjustments, bringing greater consistency and timeliness to the process.
- Developing and implementing a new risk adjustment data collection system and model, greatly reducing the burden associated with the former system.

The proposed MA rule includes additional changes designed to eliminate unnecessary burden, such as:

- Eliminating requirements on MA organizations that are duplicative of activities already conducted by CMS.
- Allowing new (non-paper) enrollment procedures in specific circumstances.
- Reducing the burden associated with disenrolling an individual for non-payment of premium.
- Providing for a more rational approach to access to care requirements in rural areas.
- Reducing burden associated with duplicative beneficiary notification requirements.

Q4: When will you publish the final regulation?

A4: We anticipate publishing the final regulation early in 2005.

B. General MA

Q1: What guarantees exist to ensure that beneficiaries who like what they have today can keep it, without change?

A1: Beneficiaries will continue to have the choice to remain in the original fee-for-service Medicare program as well as join a prescription drug plan in 2006. However, we believe that many Medicare beneficiaries will choose to join Medicare Advantage organizations that will be able to provide enrollees with a more comprehensive set of benefits, including drug coverage.

Q2: What is the basic difference between the old Medicare + Choice program and the new Medicare Advantage program?

A2: The MA program retains many of the same provisions in the M+C program such as the eligibility, enrollment, grievance and appeals provisions. There are immediate revisions to the MA payment methodology that were published in a revised 2004 MA county rate book in January 2004. A broader restructuring of the former M+C program will occur in 2006 when the payment system changes. As mandated by the MMA, CMS will move from an administered pricing system to a bidding methodology to pay MA organizations. Beneficiaries also will have an additional option from which to choose--a regional PPO plan.

Q3: Will there be more private plan options and better benefits in rural areas soon?

A3: The new Medicare prescription drug benefit will be available nationwide. The MMA contains mechanisms that guarantee that every Medicare beneficiary will

have access to a prescription drug plan, so both urban and rural residents can get their drug coverage through Medicare.

Congress also wanted to expand beneficiaries' choices for their medical benefit as well through the new Medicare Advantage program. In addition to the current plan options – which include health maintenance organizations (HMOs), local preferred provider organizations (PPOs), and private fee-for-service plans (PFFS)-- beneficiaries may be able to choose a regional MA plan. These plans will be PPOs that cover an entire region (as defined by CMS), including both urban and rural areas. Regional MA plans will be required to offer Medicare Part A/B benefits and the new Medicare drug benefit, and many will also offer supplemental benefits.

CMS will establish the number and make-up of the MA regions later this year. Our goal will be to maximize plan participation and beneficiary choices. Congress has provided numerous incentives for plans to participate in the new MA program, including incentives for health plans to offer regional MA plans. These incentives include having CMS share risk with regional MA plans during the initial contracting years, 2006 and 2007. In addition, Congress created a $10 billion stabilization fund to encourage regional MA plans to enter and remain in the program. Congress also established a fund through which "essential" hospitals can be paid additional amounts under specific conditions when they treat regional MA plan enrollees.

Q4: Do beneficiaries enrolled in Medicare Advantage plans have lower out of pocket costs than beneficiaries in fee-for-service Medicare?

A4: Beneficiaries are likely to incur lower out-of-pocket costs than they would in traditional Medicare. Recent studies indicate that beneficiaries in Medicare Advantage plans pay about $800 less on average in out-of-pocket medical costs per year, and beneficiaries in poor health may pay about $1900 less.

Q5: What benefits must regional MA plans provide that local MA plans do not have to provide?

A5: Regional plans are required to provide an annual catastrophic cap (also known as stop-loss coverage) on enrollees' out-of-pocket spending for both in-network and out-of-network costs for all original Medicare benefits including physician and hospital services. A higher cap on beneficiary cost-sharing can apply to services beneficiaries receive from non-plan providers.

C. MA Payments

Q1: Will there be any changes in risk adjustment because of this regulation?

A1: Risk adjustment (adjusting plan payments based on enrollee health status) will be used in a similar way for the MA program as it was in the M+C program. Payments for plan benefits will continue to be risk adjusted at the beneficiary level, and the phase-in to 100 percent risk-adjusted payments in 2007 will continue on the schedule in effect before passage of the MMA. For 2004, 30 percent of payments are risk-adjusted and 70 percent of payments are determined under the demographic method. In 2005 the blend will be 50 percent risk-adjusted payment and 50 percent demographic. In 2006 it will be 75 percent risk-adjusted and 25 percent demographic. (Note that payments for individuals with end stage renal disease will be 100 percent risk-adjusted beginning in 2005.) In the new competitive bidding methodology for paying MA organizations, CMS will risk adjust each plan's basic Part A/B bids and benchmarks to determine the amount of beneficiary rebate that must be used to provide Medicare enrollees with extra benefits or reduced out-of-pocket expenses (e.g., lower cost sharing or reduced premiums).

Risk adjusting payments helps to ensure that plans are paid more accurately for the health status of their members, so that plans with sicker beneficiaries are paid more than plans with healthier patients (in the same area). Likewise, if an MA plan enrolls healthy beneficiaries, it will be paid less than plans who enroll sicker beneficiaries, (in the same area).

Q2: How do payments under the MA program differ from those under the previous M+C program?

A2: In the past, CMS paid M+C organizations a monthly amount based on M+C county capitation rates. These rates were based on formulas prescribed in the BBA. M+C organizations submitted Adjusted Community Rate Proposals (ACRPs) to document how the administratively-set government payment would be used, by identifying plan costs (broken into components of direct medical costs, administrative costs and profit) for original Medicare benefits and any additional benefits being provided to M+C enrollees in a plan. In other words the ACRP was largely an accounting mechanism through which M+C organizations accounted for the statutorily determined amount of payment they were going to receive from CMS. M+C coordinated care plan member premiums for Medicare-covered services were capped based on the actuarial value of cost sharing levels in fee-for-service Medicare.

In 2006, the MMA replaces the ACRP with a plan bidding process. MA organizations will have to submit bids on an annual basis that reflect the organizations' determination of their expected monthly costs for the average

beneficiary in each plan. That is, each MA organization must identify the level of government payment it actually needs to offer its plan benefit package.

The total bid for each plan is the sum of three parts: costs for basic Part A/B benefits, supplemental benefit, and basic Part D prescription drug benefits. Plans will be paid their total bids through a combination of government payment and beneficiary premiums as determined by the relationship of their basic Part A/B bid to the "benchmark" amount, which is determined through a statutory formula.

Q3: What is a benchmark?

A3: The MMA creates a new methodology for determining payment amounts to MA organizations based on a comparison of each plan's basic A/B bid to its benchmark. The A/B bid would cover all medical services and benefits covered under original Medicare. If the plan bid is below the benchmark for A/B benefits, the government pays the plan bid amount as risk adjusted, and 75% of the difference between the bid and benchmark, which goes to beneficiaries as additional benefits (or as a decrease in premium). If the bid is above the benchmark, the government pays the benchmark amount as risk adjusted, and the beneficiary pays the difference as a premium payment.

For local plans serving a single county, the benchmark is the county capitation rate. For local plans serving more than one county, the benchmark is the enrollment-weighted average of all county capitation rates in the plan's service area, using the plan's projected enrollment as county weights. For regional plans, the benchmark is the sum of two components: (1) an administrative rate component, which is the weighted average of county rates in the region (where the weight is based on all MA eligible beneficiaries in the region) multiplied by the national FFS market share (i.e., the percentage of all Medicare beneficiaries not enrolled in MA plans); and (2) a plan bid component, which is the weighted average of plan bids in that region (where each plan bid is multiplied by the plan's share of enrollment in the region and the weighted bids are added together) multiplied by the national MA market share (1 – national FFS market share).

Q4: How do payments for local MA plans differ from those for MA regional plans?

A4: The basic bidding structure is the same for local and regional plans. For plans with basic A/B bids ***below*** their benchmarks, CMS pays the basic A/B plan bid, risk adjusted, plus the rebate amount, which is 75 percent of the difference between the bid and the benchmark. In this case, the plan's basic beneficiary premium for Medicare-covered benefits is zero, although there typically would be a beneficiary drug premium and there may be a supplemental beneficiary premium. Plans could also choose to refund part or all of the beneficiary's Part B premium with the rebate dollars. For local and regional plans with A/B bids ***equal to or above*** their benchmarks, CMS pays the plan benchmark, risk adjusted,

and the beneficiary pays a plan basic premium that is the difference between the unadjusted bid and unadjusted benchmark.

The only difference between local and regional bidding is in how the benchmarks are calculated. The regional benchmark is affected by the size of other plan bids in the region because it is based in part on the average of all plan bids in the region. The benchmarks for local plans are based entirely on rates determined by CMS based on statutory formulas.

Also, to assist the start-up of regional plans, CMS will share risk in 2006 and 2007 through application of risk corridors, which protect plans from unanticipated cost overruns and allow the government to share in any savings. If the regional plan market requires it, CMS may also tap into the stabilization fund to make payments from 2007 through 2013. [See Q&A D7 on the regional stabilization fund.]

Q5: How is risk adjustment applied in determining amounts available for beneficiary rebates?

A5: As part of determining the amount of per capita savings (of which 75% is distributed to enrollees and 25% retained by the government), the basic A/B bid and benchmark amounts are risk adjusted. There are various approaches that could be used to risk adjust bids and benchmarks (i.e. on a state-wide, region-wide, plan-specific or other basis). These options are discussed in the proposed rule. Because each option has pros and cons, CMS has asked for comment on the various options. Keep in mind that risk adjustment is applied to determine the amount of savings (the bid-benchmark comparison), the amount of rebate (75% of savings), and ultimately beneficiary-level payments. However, because beneficiary basic premium amounts (for plans with bids over benchmark) are not supposed to be adjusted for health status, they are not risk adjusted.

D. MA Regional Plans and Prescription Drug Plans (PDPs)

Q1: When will you announce the MA and PDP regions?

A1: The statute requires CMS to establish and announce MA regional plans and PDP regions by January 1, 2005. However, we hope to be able to establish and announce the regions prior to that date, so that potential MA regional plans and PDPs have more time to plan prior to having to prepare bids in 2005 for the 2006 contracting year. CMS has hired a contractor to do a market analysis and devise options for the regions. That work--which includes public input and consultations with individual stakeholders--is proceeding through the summer of 2004.

Q2: Will the MA and PDP regions be the same?

A2: The statute directs us to establish the same regions for MA regional plans and PDPs, to the extent practicable. PDP regions do not need to be the same as MA regions, if access to prescription drugs would be improved by making them different. CMS is currently conducting an analysis of key variables, including access to the Part D prescription drug benefit, to determine whether the MA regional plans and PDPs should be the same.

Q3: Will there be 10 or 50 regions?

A3: CMS is directed in statute to establish between 10 and 50 regions in the fifty states and the District of Columbia and to maximize availability of plans to all MA eligible individuals without regard to health status, especially for those residing in rural areas. Again, no decisions have yet been made on how many of either type of region we will designate, as CMS is currently engaged in conducting a market survey and analysis in order to help make the determination about the numbers of regions and how they might be configured.

Q4: Can a State be in more than one region; that is, can States be split up?

A4: While the statute does not prohibit splitting States across regions, we believe Congress did not intend that CMS divide States and put them into two regions, unless there is a compelling argument. According to the MMA Conference Report, to the extent possible, each region should include at least one State, should not divide States across regions, and should include multi-state Metropolitan Statistical Areas in a single region. We will be considering all of these elements as we develop PPO and PDP regions later this fall. Comments concerning regions may be forwarded to http://www.cms.gov/regulations/ecomments through October 4, 2004. Comments may also be provided in writing through October 4, 2004, as specified in the Federal Register.

Q5: I understand that there was a public meeting on the regions. How can I provide input based on the materials created for this event?

A5: We held a public meeting on Wednesday, July 21, 2004. The purpose of the meeting was to provide an opportunity for interested parties to ask questions and raise issues regarding options for the definition of regions for Medicare Advantage (MA) regional plans and prescription drug plans (PDPs). Further, information about a variety of region definition options is available on our website at http://www.cms.hhs.gov/medicarereform/mmaregions. Interested individuals may view a webcast of the meeting at: http://www.kaisernetwork.org/healthcast/cms/21jul04. There are two ways to

submit comments on regional definitions. First, comments following the July 21, 2004 public meeting may be submitted to aporter@cms.hhs.gov through August 5th, 2004, or through the regulatory comment process by submitting comments to http://www.cms.hhs.gov/regulations/ecomments or to www.regulations.gov , or in writing as specified in the Federal Register, through October 4, 2004.

Q6: What exactly does a PDP region do?

A6: Beginning in 2006, Medicare beneficiaries can obtain drug coverage via stand alone prescription drug plans or though their current MA organizations. A PDP region is similar to a MA region in that the United States will be divided up into between 10-50 prescription drug plan (PDP) regions in the fifty states and the District of Columbia for enrollment and bidding purposes. There will also be at least one PDP region for the territories. The PDP region is an area to be defined by CMS in which prescription drug plans will contract to provide the prescription drug benefit to all Medicare beneficiaries within the PDP region who are not enrolled in a MA-PD plan.

Q7: How does the regional stabilization fund work?

A7: The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) gives the Secretary of Health and Human Services several tools to attract and retain regional Preferred Provider Organization (PPO) plans (first available for enrollment in 2006) throughout the country as part of the newly created Medicare Advantage (MA) program.

Specifically, starting in 2007 a plan entry and retention fund will be created consisting of $10 billion with additional monies available from the plan bids. In addition, to attract beneficiaries, in instances where regional MA plans bid below their applicable regional price benchmarks, these plans can use 75 percent of the difference between their bids and the benchmarks to either provide extra benefits or to reduce premiums. The remaining 25 percent is returned to the government, and half of that amount is used to fund the plan entry and retention fund.

The Secretary can use the fund in several ways:

- If an insurer enters the program nationally (by bidding to provide an MA regional plan in all regions), then its benchmark payment in each region is increased by 3 percent. This payment is available for one year only, and it is not available if there was a national plan the prior year.
- If no regional MA plans serve a given region in one year, then the Secretary may increase the benchmark for that region for the following year. The Secretary can choose how large the increase is and how long it lasts.

- If plans decide that they are going to leave a region, the Secretary may increase the benchmark in that region in an effort to retain plans and attract new bidders. Two additional conditions must be met: the exits must result in fewer than 2 regional organizations being available, and the percentage of MA enrollment in the region must be less than the percentage MA enrollment at the national level. The Secretary can choose how high to raise the benchmark (within certain limits), and the increase can last for up to two years.

All of the above payments are subject to the overall budget limit for the plan entry and retention fund. The Secretary and the CMS actuaries must certify that there is enough money in the fund to cover the payments, and may limit enrollment in regional plans receiving the payments to make sure enough money is available.

Q8: Why are there extra payments for hospitals that won't contract with regional PPOs?

A8: Under the MMA, $25 million a year (adjusted by a market-based index) is made available to so-called "essential hospitals" that treat regional MA plan enrollees. Acute care hospitals that do not have a contract with a regional MA plan, but which treat an MA regional plan enrollee, can be paid an additional amount from the Medicare Part A trust fund if they show that their costs for providing care to an MA regional plan enrollee exceeded the amount that Medicare would normally pay for such a service. This provision of the law is, in some ways, an attempt to ensure that hospitals are not financially disadvantaged by treating members of regional MA plans with which the hospital does not have a contract. In other ways it might help a regional PPO enrollee to gain access to a local hospital that is not contracting with the regional PPO through which the enrollee is seeking care.

Q9: Why can't local PPOs be approved in 2006 and 2007?

A9: A 2-year moratorium on new local PPOs in 2006 and 2007 is intended to encourage the establishment of regional MA plans, which can begin enrolling Medicare beneficiaries on January 1, 2006. Local PPOs operating in 2005 may continue in 2006 and 2007 under the new MA rules.

E. Bidding:

Q1: I don't understand the bidding concept. How does the bidding process work? What is the process for bidding?

A1: The purpose of bidding by MA organizations is to base payment on an organization's monthly expected revenue needs rather than an administratively set amount. On the first Monday of June in each year beginning in 2005, MA

organizations will submit a bid for the upcoming year based on their determinations of their monthly-expected revenue needs, i.e. their medical and administrative costs, including profit, in their area. The bid will have three components: bid amounts for the original Medicare benefits (the basic A/B bid), basic prescription drugs, and a bid for any supplemental benefits. The level of a plan bid must reflect plan assumptions about the amount of enrollee cost sharing, and the plan bid amount for Medicare benefits (the basic A/B bid) must reflect cost sharing actuarially equivalent to original Medicare levels of cost sharing. CMS will review bids for their actuarial soundness and initiate negotiations with organizations based on the need for additional information or adjusting assumptions or portions of the bid amounts. Because regional benchmarks are partly based on plan bids, upon approval of regional plan bids in the region, CMS will compute regional benchmark amounts using approved basic A/B bids in each region and compare risk adjusted bids to risk adjusted benchmarks to determine premium and rebate amounts.

CMS has not determined the precise format of the bid submission at this time and will be announcing these specifications as soon as they have been set.

Q2: When does the MA program begin?

A2: Some of the changes made in the MMA are already in place, including the higher payment rates and the accompanying improvements to benefits or provider networks; thus we are already using the term "Medicare Advantage rather than "Medicare+Choice." However, the majority of the changes to the MA program instituted under the MMA, such as the new regional PPO plans and the added drug benefits, will take effect on January 1, 2006.

Q3: Why are you paying for ESRD beneficiaries outside the bidding process? When will you pay based on bids?

A3: Congress has allowed CMS the discretion to pay for ESRD beneficiaries enrolled in MA organizations within or outside the MA bidding process. We have proposed that ESRD enrollees be fully incorporated into the plan's aggregate bid for contract year 2007 and thereafter. However, in contract year 2006, because CMS will have implemented a new ESRD risk adjustment model in 2005, we are concerned that MA organizations will not have the necessary experience and knowledge to understand the impact of the new ESRD model on their payments, and, therefore, to allow them to bid appropriately. Hence, we have proposed three approaches to implementing the bidding process for ESRD enrollees for 2006 only. The first option would be to have MA organizations not bid on ESRD enrollees, but allow CMS to use the MMA rate setting methodology to pay for ESRD enrollees. The second option would be to not require organizations to include ESRD beneficiaries in their bids for basic Medicare benefits, but to require organizations to include ESRD beneficiaries in the supplemental portion

of the bid. The third option would be to require that ESRD beneficiaries be fully incorporated into organization bids in 2006.

Q4: Why does the beneficiary get only 75% of the savings as a rebate?

A4: The bidding model is intended to help control program costs, so it makes sense that the government would share in the savings that result when plans bid below the benchmark. Congress stipulated that the beneficiary be provided with 75% of the calculated savings, if any, from the risk adjusted bid to benchmark comparison for local and regional MA organizations. The remaining 25% of the savings will be retained by the Government in the case of local plans. For regional plans, half of the 25% of the regional plans' savings will be available for the stabilization fund.

Q5: What can MA organizations do with the rebate funds? Can the beneficiary get a cash rebate?

A5: The pre-MMA provision prohibiting plans from giving cash as an inducement to enroll remains in place. However, as is currently the case for MA plans, savings that plans achieve can be used to reduce a beneficiary's Part B premium. The MMA also allows plans to reduce the Part D premium with rebate funds.

The MMA provides that rebates must be used to provide to enrollees some combination of the following: supplemental (non-Medicare-covered) benefits or reduced cost sharing for Part A/B benefits; enhanced Part D benefits (reduced cost sharing or coverage of drugs excluded from Part D coverage); reduction of a beneficiary's Part B premium; or reduction of the premiums a plan may charge (the prescription drug premium or a premium for supplemental benefits). Rebate dollars must be used for mandatory supplemental benefits. Rebates cannot be used to fund optional supplemental benefits because this would not guarantee that the plan is providing every enrollee with the rebate dollars.

Q6: How will CMS negotiate with MA organizations?

A6: Per the MMA, CMS has the authority to negotiate with MA organizations regarding their bid amounts and the proportions attributed to basic, supplemental and prescription drug benefits in a manner similar to negotiations conducted by the Office of Personnel and Management under the Federal Employees Health Benefits Program. Although our authority may be somewhat limited by some of the statutory formulas for determining payment rates, rebate amounts, and payment amounts, we will negotiate with MA organizations to determine that bids are actuarially sound and reflect plan revenue needs and that plan benefit designs are not discriminatory. The proposed rule discusses the potential for resubmission of information from organizations via the negotiation process and adjustments to bid amounts in certain situations.

However, we may not require any MA organization to contract with a particular hospital, physician, or other entity or individual to provide particular items or services. But MA plans are required to meet certain access requirements, and may not penalize beneficiaries when provider access is limited. Also, we cannot require particular price structures between MA organizations and hospitals, physicians or other entities. In addition, we have no authority to review or negotiate bids for private fee-for-service plans or any amounts submitted by MSA plans.

Q7: Do I have to change doctors to join an MA plan?

A7: Not necessarily. Some MA plans, like Private FFS plans, will cover the care you receive from any qualified Medicare provider. Others, like HMOs, will sometimes allow you to receive limited services from non-HMO providers under a "point of service option." Yet others, like PPOs, will cover the care you receive from non-PPO providers, but your cost sharing will be higher. Before you enroll in an MA plan you should carefully consider how important it is to you to continue the relationship you have with your current doctor or doctors. You should ask your doctor if he or she is contracting with the MA plan in which you are considering enrolling. Finally, you should carefully examine the types of plans available in your area and see if one of them will allow you to see your current doctor, even if he or she is not part of the plan's network.

Q8: Can I go to any hospital for services?

A8: It depends. First of all, if you have an emergency medical condition you can seek treatment at the nearest emergency room or hospital, regardless of whether or not the hospital is affiliated with the MA plan in which you are enrolled. For non-emergencies, it depends on the type of plan in which you enroll. If there is a specific hospital in which you would like to receive your care, you should check with the hospital to see if it is affiliated with any of the MA plans in which you are considering enrollment. You should also carefully examine the MA plans available in your area to see if they cover non-emergency care provided in all hospitals, or only the ones with which they have a contract.

F. Specialized MA Plans:

Q1: Can you please describe a specialized MA plan and tell me what a plan needs to do to qualify as a specialized MA plan?

A1: Section 231 of the MMA allows MA organizations to offer specialized plans that serve special needs individuals. The legislation designates two specific segments of the Medicare population as special needs individuals. These are institutionalized individuals (as defined by the Secretary) and those entitled to

Medical Assistance under a State Plan under Title XIX (Medicaid)—"dual eligibles." Through regulations the Secretary may designate other chronically ill or disabled beneficiaries as "special needs beneficiaries" to allow plans to enroll additional high-risk groups who would benefit from a specialized MA plan. We are seeking comment on how to define groups beyond institutionalized and dual-eligibles and will provide further detail in the final rule.

Q2: How do specialized MA plans for Medicaid beneficiaries work?

A2: Specialized MA plans serving dual eligible beneficiaries can restrict enrollment into their plan to just individuals that have Medicaid coverage. Other than this enrollment provision, specialized MA plans follow all other MA plan requirements.

Q3: How does CMS define "institutionalized" for purposes of specialized MA plans?

A3: For purposes of specialized MA plans, CMS proposes to define an institutionalized individual as an MA-eligible who has resided, or is expected to reside, continuously for 90 days or longer in a long-term care facility that receives payments via Medicare's skilled nursing facility (SNF) prospective payment system--which is determined by completion of the Minimum Data Set (MDS).

Q4: What are you going to do to define special needs beneficiaries with severe or disabling chronic conditions?

A4: We will define special needs beneficiaries with severe or disabling chronic conditions in the final rule resulting from this proposed rule. In the meantime we are asking the public to help us define this term as part of our proposed rule.

Q5: When will you define plans that serve a disproportionate share of special needs beneficiaries?

A5: We will define plans that serve a disproportionate share of special needs beneficiaries in the final rule resulting from this proposed rule. In the meantime we are asking the public to help us define this term as part of our proposed rule.

Q6: Are the specialized MA plans paid differently than other MA plans?

A6: No, specialized MA plans will be paid the same as other MA plans, based on the plan's enrollment. There are no special payment features specific to specialized MA plans. However, a risk adjustment payment methodology is being phased in for all MA plans. Under risk adjustment, payments are more accurate because they reflect the health status of an organization's enrollees. In addition, CMS is currently conducting research to determine the feasibility of implementing a

frailty adjuster for the MA program. If we determine that this is appropriate, the earliest that frailty adjustment would be applied to MA plans would be 2006.

G. Appeals:

Q1: How will the proposed changes in the appeals provisions affect beneficiaries? Will they be advantaged or disadvantaged compared to the current process? What about any affect on providers?

A1: The effect of the changes to the appeals process should be transparent to beneficiaries since most changes clarify existing policy.

Practitioners would benefit from a change in existing policy that requires practitioners to issue notices to patients upon each encounter of the right to receive specific information about whether their plan will cover a service. Instead, MA plans would provide such information in the Evidence of Coverage.

We have also proposed to make the appeals procedures for Medicare cost plans identical to those used by MA plans. This would benefit all parties by bringing uniformity to the appeals procedures and eliminate the confusion associated with having different procedures for different types of plans. This change would also mean that beneficiaries who are receiving skilled nursing facility or home health services under cost plans would now have the right to an expedited review of a decision by a cost plan to terminate these services, as do all MA plan enrollees.

Finally, we have requested comment on a possible change that would give providers the option of issuing advance notices to beneficiaries that seek services that neither Medicare nor the MA plan is likely to cover. This could facilitate easier access to services for beneficiaries in such situations, without impinging on their appeal rights.

H. Quality

Q1. What will the quality requirements be under the new program? Are they different for different types of organizations, e.g., PPOs, coordinated care plans, private FFS plans? Are they different for local versus regional MA plans?

A1. The proposed rules specify that all plans, except for Private Fee-For-Service (PFFS) and Medical Savings Accounts (MSA) plans, will have to do the following:

- Conduct quality improvement projects;
- Have chronic care improvement projects;
- Report on performance measures; and

- Have health information and quality review systems.

Details of these requirements will be included in the final regulation and associated sub-regulatory guidance. The types of performance measures will differ for HMOs vs. PPOs. Local and regional PPOs will have the same quality requirements.

PFFS plans and MSAs will only be required to have health information and quality review systems

Q2. How have the quality assurance requirements changed?

A2. One of the major changes we have proposed involves the quality improvement project requirements. We no longer require a national project, just projects selected by the plans. We expect that this will allow plans to target their efforts on their enrollees' specific needs. In addition, the MMA specifies that we cannot add new performance reporting systems without Congressional approval. However, we can add or change measures in existing systems, such as HEDIS.

I. Private Fee-for-Service (PFFS) Plans:

Q1: How are private FFS plans different from the rest of private plans?

A1: Enrollees in a PFFS plan are not limited to a provider network. Members of a PFFS plan can go to any doctor or hospital in the U.S. who is eligible to be paid by Medicare and who is willing to accept the plan's terms of payment. Your cost sharing will generally be the same, no matter what doctor or hospital you use. This is different than a regional or local PPO, where your cost sharing will generally be higher if you see a doctor or hospital that is not part of the PPO's preferred network.

J. Medicare Savings Account (MSA) Plans:

Q1: What is a Medicare MSA plan?

A1: A Medicare Advantage MSA plan would combine a high-deductible insurance policy and a savings account for health care expenses. CMS would pay premiums for the insurance policies and make a contribution to beneficiaries' medical savings accounts (MSAs). The sum of the plan premium and the contribution to the beneficiary account would equal the payment made by Medicare to any other MA plan for a beneficiary. The only beneficiary premium would be a premium for supplemental benefits, if any, offered by the plan.

Beneficiaries would use the money in their MSAs to pay for their health care before the high deductible is reached. Once the deductible is met, the MA organization offering the MSA plan would be responsible for payment of 100 percent of the expenses related to covered services. The maximum annual MSA deductible is set by law. For 2005, an MSA plan's deductible may not exceed $8,450.

Q2: How are MSAs treated in the MA program?

A2: The Balanced Budget Act of 1997 (BBA) authorized a demonstration project for MSA plans when it created the M+C program. The MMA made MSAs a permanent type of plan option and lifted several restrictions that had been in effect during the MSA demonstration:

- Elimination of the time limit on enrollment and the limit on the number of beneficiaries who could enroll;
- Extension of the protection from balance billing by non-contracting providers to include MSA enrollees (in addition to enrollees in coordinated care plans). A physician or other entity that does not have a contract with an MSA plan is now required to accept as payment in full, for covered services provided to an MSA plan enrollee, the amount the physician or other entity could have collected from fee-for-service Medicare had the individual not been enrolled in the MSA plan.
- Exemption for MSA plans from certain quality assurance requirements.

K. Local and National Coverage Determinations (NCDs):

Q1: Could the changes in National Coverage Determinations (NCDs) affect the right of beneficiaries to benefit from newly-approved services or from clinical trials?

A1: No. All Medicare covered services will continue to be available to all Medicare beneficiaries, including those enrolled in MA plans. The changes to NCD coverage were made simply to identify the party responsible for payment in certain limited situations.

Q2: Is there a difference between local and regional plans when it comes to local coverage determinations?

A2: Generally there should be no difference, since the requirement is that both types of plans cover the same benefits under the same circumstances as the original fee-for-service Medicare program. However, both local and regional plans may adopt the Local Medical Review Policies (LMRPs) policies of a single carrier or FI in

the area the plan serves. For plans that cover an area in which more than one local coverage determination is applied, the law requires adopting the LMRP most favorable to the beneficiary. Since a local and a regional plan covering a given county may choose to adopt different LMRPs, it's possible that different LMRPs could apply to different enrollees in a given county, depending on which plan is selected.

L. Preemption of State Laws:

Q1: What State laws are being preempted?

A1: Broad areas of State law were already preempted prior to MMA (i.e., coverage, benefits, marketing, appeals, and treatment of providers). In addition, a general preemption authority was also in effect that preempted other State standards that were in conflict with Federal standards. Under the pre-MMA rules, however, laws generally were not preempted unless they fell into one of the above categories. Under the MMA, State standards for health plans are preempted unless they fall within one of the specific areas of State regulatory authority—licensure and solvency.

Q2: Can a company participate in the new MA program if it isn't licensed by the State in which it intends to operate?

A2: Organizations offering MA plans must be state licensed in the state or states in which it offers an MA plan(s). Under limited circumstances CMS can provide a temporary waiver of the state licensure requirement for regional MA plans. Specifically, if a region includes more than one state CMS may temporarily waive the state licensure requirement as long as the organization has a pending application for licensure with the state.

M. Comparative Cost Adjustment Program:

Q1: Are the MMA provisions that would make fee-for-service Medicare compete with private plans addressed in this regulation? How does that work?

A1: MMA provisions to which you are referring are not in effect until 2010, and then only on a demonstration basis in selected areas. This regulation does not address 2010 provisions. Closer to the effective date, CMS will publish proposed rules related to direct competition between FFS Medicare and MA organizations.

Q2: Which areas will be required to participate in the premium support demonstration program?

A2: That demonstration program will not begin until 2010. It is not the subject of these proposed rules and will be addressed at a later time.

N. MA Plans and Part D Prescription Drug Benefits:

Q1: What can MA plans with drug benefits do as far as filling the gap in coverage between the initial coverage limit and the out of pocket threshold (donut hole)?

A1: The MA-PD plan can offer additional drug benefits over the standard benefit including reduced cost sharing below or above the initial coverage limit. For 2006 the donut hole falls between the initial coverage limit of $2,250 and the out-of-pocket limit of $3,600. This supplemental benefit can be funded by the plan with beneficiary rebate dollars (available to plans that have basic A/B bids below their benchmarks), or by charging a beneficiary supplemental premium, or by a combination of rebate dollars and supplemental premium. This means that MA plans may increase the initial coverage limit above $2,250, and the MA plan may "fill in the donut hole".

Q2: Can local and regional MA plans offer a plan with no Part D (prescription drug) coverage?

A2: An MA organization can offer an MA coordinated care plan in a service area -- either local or regional – only if that plan, or another MA plan offered by the same organization in the same service area, includes required prescription drug coverage.

This rule applies only to coordinated care plans. By law, all regional plans are coordinated care plans. However, there are 4 types of local plans: coordinated care plans, cost plans, MSA plans and private fee-for-service (PFFS) plans. MSA plans will not offer a drug benefit. PFFS plans and cost plans are not required to offer a drug benefit.

Q3: Can a beneficiary who enrolls in an MA plan with no prescription drug coverage choose to sign up for Part D on the same basis as a beneficiary in original fee-for-service Medicare?

A3: This depends on the type of MA plan the beneficiary elects. The MMA specifies that MSA plans may not offer Part D coverage and PFFS plans and cost plans have the option of offering Part D coverage. So, if the beneficiary enrolls in an MSA plan or a PFFS or a cost plan that does not offer Part D coverage, s/he may

also enroll in a Prescription Drug Plan (PDP). If the beneficiary enrolls in a coordinated care plan, s/he cannot enroll in a PDP.

Q4: In what ways do MA-PD plans operate like PDPs and in what ways can they operate differently?

A4: MA-PDs can use the CMS funds they receive in excess of their bid to "buy-down" the cost of Part D benefits as a Medicare Advantage supplemental benefit. (MA plans receive 75% of the difference between their bid and benchmark). This is different than what PDPs can do, since PDPs can only receive, as a maximum payment from CMS, their bid amount. Therefore, in relation to Part D benefits, it seems clear that there is a distinct potential that MA-PDs will be able to offer a more comprehensive or competitively priced product than will PDPs.

O. Lock-In:

Q1: When does the lock-in take effect?

A1: The Medicare Advantage (MA), Open Enrollment Period (OEP) limitations (also known as "enrollment lock-in") takes effect beginning January 1, 2006. The Medicare Modernization Act (MMA), section 102(a)(1)(A), makes this change by amending the Social Security Act, section 1851(e)(2).

Q2: What is the lock-in requirement for 2006? For 2007? Can I change plans or go back to traditional Medicare once I have selected an MA or MA-PD plan?

A2: The open enrollment period in 2006 will be the first 6 months of 2006. The open enrollment period for 2007 and subsequent years will be the first 3 months of each year.

People are generally locked into their plan for a year when they enroll, with certain exceptions:

Annual Enrollment Period: Every year, you will be able to choose another Medicare prescription drug plan or Medicare Advantage plan during an annual open enrollment period that lasts from November 15 through December 31. Coverage under the new plan will begin January 1 of the following year.

One time switch: By law, people in Medicare Advantage plans will have one opportunity during the first three months of each year to switch to another Medicare Advantage plan or to Original Medicare as long as individuals maintain the same type of prescription drug coverage, either through a similar MA plan or through Original Medicare.

Other exceptions: You may also have another opportunity during the year to switch plans, depending on the circumstances. For example, if you move out of the service area of your plan, you'll have an opportunity to choose another plan that serves your area.

Q3: If I drop my Medigap plan and go into an MA plan, can I go back to Medigap if I am unhappy?

A3: Yes, in limited circumstances. If you drop your Medigap policy to enroll in a Medicare Advantage plan and this is the first time you've ever enrolled in an MA plan, a cost plan, demonstration project, PACE program, or Medicare Select plan, you can get your Medigap policy back if you disenroll from the MA plan within the first 12 months of your enrollment. You have the right to buy back your former Medigap policy, if the same issuer still sells it. If your former Medigap policy is not available from the same issuer, you have the right to buy Plan A, B, C or F from any Medigap issuer. If your former Medigap policy contained prescription drug coverage, you will not be able to buy back that policy with drug coverage after January 1, 2006 because Medigap issuers cannot sell Medigap policies with prescription drug coverage after December 31, 2005. In this case, you have the right to buy back your former policy without the drug coverage (from the same issuer) or to buy Medigap Plan A, B, C or F, or the new plans required under the MMA, which we expect will be designated K and L, from any issuer that sells these plans. (If you want drug coverage, you have the option of enrolling in a PDP).

Q4: What happens to Medigap policies with drug coverage when the new Part D coverage goes into effect?

A4: Effective January 1, 2006 sales of new Medigap Rx policies will be prohibited, and drug coverage must be eliminated from Medigap Rx policies held by beneficiaries who enroll under Part D. The statute only permits the renewal of Medigap Rx policies if the policy was purchased prior to January 1, 2006, and the individual does not enroll in Part D. Therefore, a Medigap policy including prescription drug coverage could not be sold after January 1, 2006 after it had been dropped.

P. MA Payment in 2004 and 2005 (before competitive bidding starts in 2006):

Q1: How did the methodology for setting rates in the MMA change from the method in use before the MMA?

A1: Under the BBA, the M+C capitation rate for a year was the highest of three rates: a “floor” amount reflecting a minimum specified in statute, a blended rate combining local and national data, and a minimum percentage increase rate of 102 percent of the prior year’s rate.

Beginning in 2004, the MMA returned to the pre-BBA approach of linking managed care payments to local FFS costs by introducing a new rate 100 percent of average per capita local FFS costs. For 2004, rates are based on the highest of four rates, the three M+C rates and the 100 percent FFS rate. This local FFS rate will be calculated at least every three years and more often as CMS determines. The MMA redefined the minimum increase rate to be the prior year's rate increased by the higher of 2 percent or the Medicare growth percentage. For 2005, the MA payment rate becomes the higher of the minimum increase rate or the 100 percent FFS rate.
In succeeding years, the MA rate is the minimum increase rate, except in years when CMS rebases the FFS rate. In these years, the rate is the higher of the two.

Q2: Why weren't the 2004 rates adjusted for VA and DOD costs?

A2: In order to incorporate the costs of services provided at VA/DOD facilities into the MA rates, it is necessary to obtain reliable data on a county level to make the adjustment. As of this date, we have not been able to obtain such data. In addition, it is not clear how much of an impact this data would have on the MA rates.

The impact of such an adjustment could be different based on the current program experience compared to the prior program experience. For example, the DOD program has been replaced by Tricare for Life so any data we use to implement this provision must be recent data reflecting this change. We will continue to work towards finding reasonable data sets to make such adjustments for both the VA and DOD programs. However, due to the short time frame to revise the 2004 rates and to announce the 2005 rates, we have not yet been able to determine such adjustments.

Q. Federally Qualified Health Centers:

Q1: Do MA plans have to contract with FQHCs? How does the MMA change payments for FQHCs that contract with MA plans?

A1: MA plans do not have to contract with FQHCs. The MMA provision regarding FQHCs ensures that they continue to be paid the same rate they would have received for similar services provided to FFS beneficiaries. CMS will make trust fund payments to FQHCs in an amount that makes the FQHC "whole," once the MA plan has made payment of the "normal amount" it would have paid for the same service provided by another of its contracted providers.

R. Emergency Admission Charges

Q1: Why have you proposed to change the amount enrollees can be charged for emergency department care?

A1: We haven't proposed to change the amount from $50. We have simply proposed to clarify that this limit applies only to services provided in the emergency department, as we had intended originally.

S. Health Savings Accounts

Q1: What is an HSA?

A1: HSAs, or Health Savings Accounts are found in a separate title of the MMA and are regulated by the Department of the Treasury. Current Medicare beneficiaries are not eligible to create HSAs. Briefly, however, HSAs are tax-advantaged savings accounts established exclusively for the purpose of paying qualified medical expenses of the account beneficiary who, for the months for which contributions are made to an HSA, is covered under a high-deductible health plan. The HSA account can be used to pay for medical expenses incurred by individuals, their spouse or their dependents. No permission or authorization from the Internal Revenue Service (IRS) is necessary to establish an HSA. An HSA is established for the benefit of an individual, is owned by that individual, and is portable. An individual who is an employee may establish an HSA with or without involvement of the employer, and if the individual later changes employers or leaves the work force, the HSA does not stay behind with the former employer, but stays with the individual.

Q2: When will HSAs be available?

A2: Beginning January 1, 2004, individuals who are eligible to establish an HSA may do so with a qualified HSA trustee or custodian, in much the same way that individuals establish IRAs or Archer MSAs with qualified IRA or Archer MSA trustees or custodians.

Who is eligible to establish an HSA. An eligible individual means, with respect to any month, any individual who**:**

- is covered under a high-deductible health plan (HDHP) on the first day of such month;
- is not also covered by any other health plan that is not an HDHP (with certain exceptions for plans providing certain limited types of coverage);
- is not entitled to benefits under Medicare (generally, has not yet reached age 65); and
- may not be claimed as a dependent on another person's tax return.

For example, an individual who attains age 65 and becomes eligible for Medicare benefits in July 2004 and had been participating in self-only coverage under an HDHP is no longer eligible to make HSA contributions (including catch-up contributions) after June 2004.